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ABSTRACT

Following a brief introduction, this paper focuses on how the Texas Project for Elders, one of ten sites in the country participatng in the National Long-Term Care Channeling Demonstration Project (Channeling), has taken into account the mental health needs of clients and caregivers both in the development and delivery of services. The clients served by Channeling are described in terms of age, sex, referral sources, and presenting problems. The general role of the Channeling case manager in both basic and complex organizational models is explained, while the basic model, which was specifically implemented in the Texas Project, is described in greater detail. The staff organization, staff to client ratio, and the basic assumptions that guided the development of services (i.e., a high prevalence of untreated mental health problems, the need for an interdisciplinary approach, case managers as advocates and negotiators, and the need to address the mental health needs of caregivers) are presented. The preparation of the case managers is discussed including such training foci as problem identification, communication techniques, client assessment, and information synthesis. Interagency relationships with psychiatric settings are described. Service delivery experiences are presented including data on mental health problems, interventions (e.g., community and in-home consultations and counseling services), and the particular demands of the case manager role. The paper concludes with an overview of the project highlighting its uniqueness in regard to population served, staff roles, and services provided. (BL)

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ELDERS

TEXAS PROJECT FOR ELDERS: ASSISTANCE WITH LONG-TERM CARE

Serving Impaired Elders

in the Community: The Interface

of Case Management with Mental Health Services

36th Annual Meeting

The Gerontological Society of America

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Introduction

The target population being served and studied by the National Long-Term Care Channeling Demonstration Project (known briefly as channeling) includes elders older than 65 who, without some community intervention would enter a nursing home or remain there. To enter the programs, elders must participate in the research, wish to remain in or return to the community, and have multiple functional impairments and unmet service needs which are predicted to continue for at least six months or cannot be met because the individual's informal support system is fragile.

The clients' functional limitations may be due to chronic physical or mental health disabilities or an interaction of chronic disabilities and losses, socioeconomic problems, and enviornmental handicaps. Mobility limitations are common among clients; a large percentage (in Texas around 15%) rarely, if ever, leave their homes.

This presentation will focus on how Texas Project for Elders, one of the ten sites in the country participating in the channeling demonstration, has taken into account the mental health needs of clients and caregivers both in the development and delivery of services. Texas Project for Elders is the only channeling agency which has been developed and operated by a mental health facility. Therefore the experiences of TPE are not necessarily representative of the project as a whole. Specific strategies for linking case management services with mental health care and training case management staff to cope with emotional problems and psychiatric needs of clients and caregivers will be discussed.

Clients of Channeling

Time does not allow for a detailed profile of the 4000 clients who have entered the national channeling program. Nearly half or 44% of all channeling clients are aged 75-84 years, with 28% younger than 75 and 28% or older. Women outnumber men 71% to 29%. About three-fourths of all channeling clients have Medicare coverage only and an additional 21% have Medicaid coverage. Many live alone (34%), or with a spouse only (29%). Living with children (16%) or in some other community arrangement is also fairly common.

The largest referral sources for channeling clients have been family/friends/self (28%), hospitals (21%) and home health agencies (15.2%). Psychiatric facilities have accounted for less than 1% of all clients referred to channeling. Although there is large variation in how screeners at different sites record presenting problems, twenty-seven percent of all clients were identified as having mental or psychological problems. All ten sites have elders with impaired mental status, depressive symptoms, and other emotional problems as well as elders and caregivers who are undergoing stresses and losses which place them at high risk for developing emotional problems and mental illness.

Role of the Channeling Case Manager

"Channeling", a relatively new word, is the specific intervention used in this project to arrange and coordinate services needed by impaired elders trying to remain in the community. The national channeling program is testing

two organizational models of community long-term care services for people older than 65 who are functionally impaired. The basic model uses the case management process to coordinate existing community resources to meet individual needs. The complex model uses case management strategies with control over a funding pool of public dollars (Titles XIX, XX and III) and the ability to gain access to expanded services through waivers.

Basic model channeling sites do not have any ascribed decision-making authority over available community resources or public benefits. The basic model inserts case management into the existing service system; it must rely on negotiated agreements and relationships with existing providers to gain access to and coordinate services for impaired clients and generally, to ease the confusing logistics of the community system.

Channeling in Texas

The agency chosen to implement a basic model site in Houston, Texas, was the Texas Research Institute of Mental Sciences (TRIMS). TRIMS is the research, training and patient care facility of the Texas Department of Mental Health and Mental Retardation (TDMHMR). Working through a subcontract with the Texas Department of Human Resources, TRIMS began developing the Texas Project for Elders in March, 1981. Service delivery began in February, 1982, and will continue through December, 1984.

As an outgrowth of the Gerontology Center of TRIMS, Texas Project for Elders (TPE) has focused on the mental health aspects of community long-term

care from its earliest organizational days. The Texas Project for Elders has a total of twelve professional staff members with backgrounds in nursing and social work. A case management supervisor and six case managers currently serve a total of 335 clients who live in a service area covering more than 710 square miles of Houston and Harris County.

The experiences of TRIMS' other programs guided the staff of TPE in developing case management services for impaired elders. The planning staff made these assumptions:

1. Although the prevalence of psychopathology increases with age, older people are less likely to be seen by a mental health professional than any other part of the population. Therefore, several clients would likely have untreated emotional and mental health problems.

2. If appropriate care plans were to be developed, case managers would need to be able to recognize and describe possible symptoms of mental illness, to view the older person in a comprehensive way, and to understand inter-relationships between physical, social and psychological problems. Arranging comprehensive care for impaired elders would require case managers to work closely with professionals of other disciplines.

3. Obtaining mental health services for clients would require case managers to be careful negotiators, overcoming several obstacles like resistance of family and clients, transportation problems, lack of available resources, limited financing of available resources, and attitudes of physicians and other providers.

4. Family and friends provide most of the care essential to keeping impaired elders at home. The caregivers of clients with obvious mental impairments were likely to be neglectful of their own physical and mental health.

During the planning phase and early operations of the project, TPE initiated specific strategies designed to prepare case managers to cope with mental health problems, to insure maximum client access to available psychiatric services, and to help caregivers.

Preparation of Case Managers

Of the seven staff members hired to work in the TPE case management unit, only one had any prior training in mental health intervention, although this did not include extensive information on geriatric mental health. The orientation and initial training of all case managers included material on available community resources for out-patient and in-patient treatment and current health insurance coverage of mental health services.

Initial and follow-up didactic lectures delivered by TRIMS psychology and psychiatry staff covered information about normal psychological changes with age, cognitive dysfunction in the elderly, and affective disorders in late life. The lectures prepared case managers to recognize problems needing further evaluation and provided information on routine evaluation and treatment procedures for common mental disorders. Helping older people and clients overcome the stigma and fears associated with psychiatric treatment requires staff knowledgeable about what mental health treatment entails and comfortable

about recommending treatment. Early training also included suggestions on how to approach clients and families about seeking counseling or psychiatric care. With increased experience in serving clients, case managers have posed more specific questions on the relationships between physical and mental health conditions and how to identify situations requiring professional evaluation. One of the most difficult issues to address has been how to determine whether an individual's limited social functioning is due to physical disability, "learned helplessness", mental disability, or an interaction of everything.

As part of the early training with mental health professionals, case managers learned how to evaluate responses to sections of the assessment tool designed to identify problems with an elder's mental functioning. The channeling assessment tool includes the Short Portable Mental Status Questionnaire (SPMSQ), excerpts from CES-D depression scale, probing for problems with sleep, appetite, anxiety, etc., questions which identify a client's social interactions and feelings of life satisfaction, and the assessor's observations about the elder's mood and behavior.

After conducting some client assessments, case managers were given opportunities to ask professional questions about the meaning of information collected during in-home visits. The importance of integrating information on such dimensions as client nutrition, performance of activities of daily living (especially problems with meals, finances, shopping and dressing) with other assessment data on mental functioning, health conditions. and medication use was emphasized.

The ability to synthesize assessment data on current or potential mental health problems was only one of several skills required by the case managers. As specific problems were identified, the project director and supervisor worked with staff members to mobilize client, family, and physician support in getting appropriate specialized services. Establishing priorities for mentally impaired clients with multiple impairments often required multi-disciplinary input. Supervisory staff experienced with multidisciplinary collaboration modeled telephone consultation calls with physicians demonstrating how to give brief relevant facts and request further medical evaluation.

Interagency Relationships with Psychiatric Settings

In addition to training staff members on mental health issues prior to initiating service delivery, TPE established formal linkages with available community mental health services via interagency agreements. Having a clearly established linkage with mental health services was considered as significant as linkages with home health agencies or home delivered meals programs. The agreements established with the Geriatric Clinic of TRIMS and the Geriatric Services Unit of Harris County Mental Health and Mental Retardation Authority specified referral procedures for mental health evaluation and treatment services. Other areas covered in the agreements included exchange of information between programs, confidentiality standards and methods of ongoing communication. Fortunately, Houston has two programs with specially trained staff, however, this has not been the experience of all ten channeling sites. In some instances complex model sites with resources

to purchase geriatric services have been unable to find trained providers.

Training for case managers was supplemented with resource information on general hospital facilities with psychiatric services, support groups for caregivers involved with clients with Alzheimer's Disease, Parkinson's and other physical disabilities with associated emotional problems, and procedures for involuntary psychiatric commitment. Legal issues associated with psychiatric care and protective services was the subject of an in-service session in the first six months of service delivery.

Although the need for in-home psychiatric consultation was considered before beginning services, satisfying such a need seemed impossible. A client requiring home evaluation entered the project within the first month, however, and the urgency of the situation unlocked an unexpected resource. With permission from supervising faculty members, the first of several TRIMS psychiatry and psychology fellows participating in one-year NIMH-funded postdoctoral fellowship training programs began doing home evaluations for TPE clients. This linkage has continued through two classes of fellows. As their schedule permits, TRIMS fellows have been able to provide in-home evaluations of mental functioning for care plan decisions about guardianship or home management. They have made recommendations about further treatment needs including therapy, medication, and hospitalization, and have helped case managers obtain these services where possible. Although the psychiatry and psychology fellows have not been able to provide ongoing treatment, they have conferred with primary care physicians by phone, participated in interagency staffings and

prepared written evaluations used for guardianship proceedings or hospital admissions.

Service Delivery Experiences

Channeling clients and caregivers have presented the full spectrum of mental disorders of late life, from short-term situational adjustment reactions to attempted suicides by two male clients with no previous psychiatric history. Precise data on the prevalence, onset, and etiology of mental health problems and corresponding treatment responses cannot be reported at this time. However, the staff estimates that approximately 8% of a total 565 clients entered channeling with a history of psychiatric treatment. About half of them had received in-patient care. Further, according to self-report or proxy statements at assessment, approximately 30% show depressive symptoms, approximately 35% appear to have some evidence of dementia and about 7% exhibit behavioral problems such as wandering, aggression, etc. Concerning intervention, case managers have been involved in arranging for psychiatric hospital care for roughly 2% of all clients served, public out-patient care for another 3%, and private out-patient psychiatric care for another 1% of the total 400 clients served in 20 months. The only resource available for ongoing in-home counseling is a United Way social casework agency which has professional social workers specializing in aging. Approximately 12% of all clients have been referred for these services. This means efforts have been made for roughly 1/5 of all clients to receive professional counseling or psychiatric services.

Despite the availability of some publicy supported mental health services and local geropsychiatry and geropsychology professionals, the majority of TPE clients who have displayed symptoms of depression or dementia have never seen a mental health professional. This is due to several factors including the limited mobility and physical frailty of many clients, lack of transport resources, and limited entitlement benefits for mental health coverage. Therefore, case managers have had to learn over time how to work with physicians to call attention to possible mental health problems. This has varied from arranging telephone consultations between a treating primary practitioner and publicly employed psychiatrist to working through home health nurses who are intimately involved with a patient and can discuss client needs with the physician. Case managers have had to bring therapeutic optimism and persistence to the task of pursuing evaluation and treatment of mental health problems. They have also had to use their understanding of mental health needs to creatively utilize other services aimed at increasing an elder's social activity or stimulation such as friendly visiting, home activities or exercises, day care, etc.

The availability of in-home psychiatric/psychological consultation has been critical to outcomes with some clients. Thirteen consultations from TRIMS fellows have resulted in hospitalization for 2 clients, protective guardianship for 3, and specific medication recommendations for primary physicians in 4 cases. The need for in-home mental health consultation to evaluate client problems or caregiver needs and to give the case manager and

family specific recommendations for further treatment or home management has exceeded the time available from geratric trainees available for this purpose.

Being able to observe the in-home consultations has allowed case managers to increase their understanding of the "art" of assessment as it relates to mental health issues. They have learned how to probe for significant medical and social history information and to pursue family dynamic issues with more understanding. They have also been able to discuss management techniques with a consultant familiar with the client and her surroundings. This experience has offered them additional confidence and enthusiasm for pursuing treatment or trying other interventions with clients. Although clients and/or family members have sometimes refused referrals for out-patient care, only on one occasion has a highly suspicious client refused to have a consultation visit from the psychiatrist or psychologist accompanied by the case manager. Likewise, only one physician has refused to confer with a consulting mental health professional when this was arranged by the case manager with client and family consent.

Almost all of the 20 interagency case conferences convened by project staff have concerned clients with some organic or functional mental disorder. Fortunately, trained mental health specialists have been involved as consultants or participants in half of these conferences, with a psychiatrist or psychologist present at 3 of the conferences.

Anecdotal case material and case recordings can well document the excessive time and emotional demands of serving this subgroup of clients needing long-term care. The needs of older spouses and other family members have also been prominent in care plans. Some in-home consultations and mental health referrals have been precipitated by a caregiver's need for information, home management suggestions, or emotional support. One project staff member has organized an ongoing caregivers' group, which runs on a psychoeducational model with professional leadership, and has written a handbook for caregivers that includes a chapter on caregiver stress. Clearly, the tasks of constant care for a mentally or physically disabled individual affect the caregiver's physical and mental health which, if left unattended, can result in the breakdown of community care for the client.

Case managers have tried to help clients and families anticipate potential stressors or to resolve problems which might result in future emotional problems. Working with established family dynamics which work against meeting a client's basic needs for care has presented a particular challenge. In many situations case managers have had to struggle to keep other providers involved with clients with behavior problems or impairments that could not be addressed until a crisis erupted. Responding to urgent mental health needs of physically frail clients and caregivers has often taxed the emotional health of case managers. The availability of professional consultation and support from cooperative mental health agencies has been critical in handling these situations.

Conclusion

The channeling demonstration is serving a very impaired aged population, who with help from informal caregivers and formal services, is trying to remain in the community. The impaired elders served by channeling include some individuals whose mental disorders have been identified and other elders with social situations, physical disabilities, economic circumstances and environmental handicaps which place them at high-risk of developing mental health problems.

Identifying and meeting the mental health needs of clients has required a case management staff knowledgeable about processes of normal aging as well as psychiatric disorders of late life. Furthermore, case managers have needed to rely on the consultation servcies of trained psychiatrists and psychologists and to work closely with primary care physicians serving clients. Some channeling clients have been victims of abuse or neglect or have displayed markedly impaired judgment that requires protective services intervention with psychiatric support.

Out-patient and in-patient psychiatry services have been essential resources for a significant portion of channeling clients and case managers have played important roles in obtaining these services for clients. Even with services available from a psychiatric training institute, a specialty county mental health authority, and a family service agency, TPE has been unable to adequately meet the identified mental health needs of clients. Among the most prominent are the needs for in-home counseling for homebound elders and spouses, home management education for caregivers of clients who have dementia, and hospital-

ization services for elders with physical and mental impairments. All of the experiences of the channeling project in Texas reinforce the importance of increasing linkages between primary medical services and geriatric mental health services and expanding the number of trained professionals concerned with the mental health needs of elders. Programs organized to help functionally impaired elders remain in the community need to have access to a full range of professional psychiatric services and a staff of professionals who understand mental disorders of late life and the value of mental intervention in late life.

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